Exhibit B: DHCFP Questions for Written Testimony

LAWRENCE GENERAL HOSPITAL TESTIMONY
March 3, 2010

Questions

1) After reviewing the preliminary reports located at www.mass.gov/dhcfp/costtrends please provide commentary on any data, or finding that differs from your organization's experience and the potential reasons therefore.

RESPONSE:

Summary: Lawrence General Hospital is a DSH community hospital, high Medicaid provider with 189 licensed beds, serving primarily Lawrence, Methuen, Andover and North Andover. The Hospital, in partnership with the independent health center in Lawrence, has a 24-resident family practice residency program which has enhanced access to primary care for the City of Lawrence. Our organization's experience highlights one of the major findings. That is, certain providers, especially DSH providers, lack leverage. Beyond that, our experience differs from the trends detailed in the state's report in the following ways:

- We have a low primary and specialty physician to population ratio
- We have seen a modest increase in outpatient services

Detail: Since Lawrence General Hospital is an independent, high public payer hospital, and most of our primary care physicians have remained unaffiliated with an academic medical center, we believe our rates from private payers are lower than market. We do not have market leverage and our rates are lower relative to other hospitals. Although we have seen a modest increase in outpatient services volume and revenue, it is substantially below statewide increases. The Hospital competes with large physician groups who provide imaging services such as mammography. Doctors are not sending patients to the hospital setting because they have made imaging equipment investments.

While Massachusetts has a high physician to population ratio, the Lawrence area currently has shortages in both primary care and specialty care. Many primary care providers are not accepting new patients and consultant reports have identified specialty shortages.

2. Do you see trends in your revenues, from 2006 to 2008 or more recently, that differ materially from these aggregate trends with respect to:
   a. The rate of change in outpatient facility prices and faster revenue growth compared with inpatient revenues;
   b. The growth of revenues for outpatient imaging services;
   c. Price changes versus other sources of growth in revenues, for inpatient and outpatient services.

RESPONSE:

Summary: The Hospital's average outpatient utilization growth trend for 2006 to 2008 was 5%, and its outpatient net patient service revenue growth rate for private payers was 7.5%, substantially lower than statewide. The inpatient average utilization growth trend for the period was 0.9% and the

revenue increase for private payers averaged 4% for the period. We have experienced consistent large increases in observation utilization but not in imaging. It is not clear that price increases have driven the growth in revenues. It appears to be a combination of price increases, utilization increases and service mix.

Detail: The Hospital's outpatient visits for the period 2006 – 2008 increased 7% in 2007 and 3% in 2008. We had a 3% growth in inpatient admissions in 2007 but a 1% drop in 2008. Outpatient utilization has grown faster than inpatient admissions during the period which is consistent with the report. Our Emergency Center gross revenue has grown due to a lack of primary care in the market and a new facility that opened in 2006. Emergency room visits increased 5% in 2007 but only 0.5% in 2008. We have had some revenue growth for outpatient imaging services but perhaps not as great as other facilities due to physician office competition and managed care restrictions. The observation trend is a result of payer determinations of level of care for payment purposes and is not driven by patients. Resource use can be equivalent to an inpatient stay. This trend negatively affects our payment rates and is a misleading component of the increase in "outpatient" services. Utilization trends for outpatient services, changes in service mix and price increases all seem to be driving revenue growth. Net revenue growth for 2008 over 2007 was negatively affected by significantly reduced Medicaid payments.

3. What are the one or two most important underlying causes of your experience, as described above? Provide any information you have that will support your assertions. In particular:

a. What accounts for the growth in inpatient facility prices? What accounts for the growth of hospital outpatient facility price per service? What accounts for the growth in utilization of outpatient hospital facility services? Do you foresee the same factors continuing to drive the growth in total facility revenues in future years?

b. How does your relative market position or market share affect your cost or revenue trends?

RESPONSE:

Summary: Our payer mix determines our ability to influence our payments for services. Private payer contracts account for only 24% of our revenue while government payers and self-pay accounts for 71% of our revenue. We have a weaker market position for contracting leverage than some nearby competitors that are part of larger systems, which limits our ability to negotiate substantial increases, or make up for public payer shortfalls. Our new emergency center has attracted more patients. Payer pressure to shift inpatients to observation status has been a large component of our outpatient utilization increase. Volume has not impacted future revenue trends overall but has required the hospital to reduce costs in order to remain stable. Service carve-outs by the payers are a negative impact to the hospital.

Detail: Despite our challenging payer mix, we have been able to negotiate increases with the commercial payers. At the same time our state revenue has been significantly decreased due to the budget cuts. Medicaid rates have declined, Medicaid DSH payments have been eliminated and Health Safety Net Fund rates declined as well. In general, our payer contract increases have been more heavily weighted to the inpatient side than the outpatient side because historically our inpatient payments had been below market more than the outpatient payments. Also payers have been trying to hold costs down on outpatient services and have offered more flexibility on the inpatient side.

We attribute growth in emergency center volume to our new facility and a lack of primary care access in our service area. This is supported by data that shows of the emergency visits billed, as many as 10% are billed at a Level I E&M code, i.e. low intensity visits that probably could have been provided in a doctor's office. Many primary care offices in our area have closed panels and are not taking new patients. Also, many of these visits occur during weekdays, when doctors' offices are open, indicating a lack of access or a population without a primary care affiliation. The emergency services growth is also partly attributed to our new 30,000 sq. ft. facility that vastly increased our number of treatment rooms when it opened in 2006.

A new contracting trend to designate preferred networks for certain services such as laboratory services is problematic for hospitals. Hospital labs cannot match the cost efficiency of free standing labs and as this volume is steered away from the hospital overhead lab costs cannot be eliminated because of inpatient demands. Thus the remaining volume has to be reimbursed at a much higher level to support the service... However, we may not have the market clout with the payers to achieve the higher rates of reimbursement to make up for the loss in lab volume. Our elective outpatient volume is sensitive to market demands so we have to remain competitive, and improve our physical plant, physician complement and quality of care in order to fulfill our mission to our community.

4) The concentration of teaching hospitals in Boston means that tertiary hospitals effectively serve as the "community hospital" for many patients. If your hospital is located in Boston, what reasonable solutions could your organization develop to provide routine care in less expensive – but appropriate - settings? If your hospital competes for patients with a teaching hospital outpatient facility, how has this impacted your revenues, costs and service mix?

RESPONSE: This question is not applicable for Lawrence General Hospital.

5) Overall, we found an increase in the proportion of services being provided in more expensive settings. Is this trend occurring in your market area? What is driving this trend and what solutions would moderate this trend without impacting quality?

RESPONSE:

Summary: Yes, this trend definitely occurs in our service area as we are located not far from Boston and Burlington (Lahey Clinic). We have a limited marketing budget and rely on quality of care, physician relations and our reputation primarily to attract patients. The outmigration to Boston negatively affects our payer mix, exacerbates the workforce shortage, and drives up our labor costs because we have to compete with Boston salaries. The outmigration occurs because major academic medical centers have enjoyed higher reimbursement over a long period of time that has enabled them to attract specialists, build capacity, and market their services. Another huge factor is that the cost to patients of choosing to receive care at a higher cost hospital is equal for either the high cost or lower cost setting. Possible solutions are for health plans to design benefit plans that favor community hospitals for appropriate care and payment system redesign.

Detail: The Boston hospitals have marketed directly to and attracted private pay patients at the expense of community hospitals such as ours, leaving us to serve a disproportionate share of those relying on public payment, the uninsured and under-insured. In addition to the related revenue impact, this has a cost impact on us. The higher rates of reimbursement in Boston have driven up staff salaries and the community hospital has had to pay higher wages to attract and retain staff without the volume or reimbursement to support it. The leakage to tertiary facilities has increased

since payers and providers curtailed commercial HMO risk contracts that had been in place ten years ago. If benefit designs with higher co-pays at tertiary hospitals for non-tertiary level of care were adopted by employers that might help mitigate the trend. In addition, a payment system that would allow community hospitals to fund physical plant and quality improvements would help them keep patients and physicians in the lower cost community hospital setting.. Risk-sharing can work to mitigate the trend if designed appropriately as well, but risk arrangements historically never eliminated leakage to Boston.

6) From 2006-2008, what was your average annual increase in labor costs compared with your average annual increase in patient revenue? What are the major factors driving change in labor costs? What are the major factors driving change in patient revenues?

RESPONSE:

Summary: Our average annual increase in labor costs was 1% below our average annual increase in net patient service revenue. The major driver for labor costs has been the double digit increase in union salaries for each of the past three years. On the revenue side, the departure of six physicians from the Lawrence General market to practice at other local hospitals due to more favorable (higher) rates and payer mix, have caused increased pressure on patient revenues.

Detail: The average annual increase in labor costs for 2006 – 2008 was 7.6%. The average annual increase in net patient service revenue for the same period was 8.9%. The Massachusetts Nurses Association has demanded and received significant increases while non-union employees have only received inflation or below inflation increases each year. Union activity definitely has a role as a cost driver in Massachusetts. We were able to manage and control the rate of growth in FTE's, keeping them nearly constant for 2008 over 2007. Patient revenue depends on patient loyalty, health of the population, physician complement and loyalty and reimbursement. During this period we had a significant decline in government reimbursement with some increases in private payer rates (but not offsetting), some increases in utilization but not consistent trends. We are actively working on ways to ensure primary care access in our community and stabilize practices through enhanced payment rates with payers. We formed a PHO during 2008 to try to improve contracting leverage in our community.

7) Are the costs of acquiring medical equipment and technologies increasing, decreasing, or staying the same? Why and how do you think this is the case? What contribution is this having on your overall costs?

RESPONSE:

Summary: The cost of acquiring medical equipment and technologies is increasing. While our capital spending is limited by our capacity to fund acquisitions from operations and modest borrowing, the acquisition of equipment does increase costs. A certain level of spending is critical to replace existing equipment, and influence patient preference in seeking health care services and physician preference in a competitive hospital market. The clinical information systems required by the state will cost the Hospital $6M over the next two years. The support of federal and state funding is the only way this investment will be possible.

The following questions relate specifically to your experience in service prices and mix of services provided:

8) What factors do you consider when negotiating payment rates for inpatient care and outpatient services? Please explain each factor (e.g., labor costs) and rank them in the order of impact on negotiated rates.

RESPONSE:

Summary: In general, we strive to cover our costs of caring for the patients of the insurer with whom we are negotiating overall, plus a small margin to contribute to capital investment and government payer shortfalls. In reality, our ability to negotiate rates to that level is limited. The payers cite budget constraints, premium competitiveness, peer group relativity and lack of willingness to subsidize government payers as reasons for not agreeing to proposed increases. Yet as an employer, we do not see the benefit of lower premium increases passed on to us by the same payer who holds us to lower payment increases.

Detail: Lawrence General Hospital does not have a cost accounting system, but we can track direct and indirect costs by payer compared to net revenue to determine profitability of contracts by payer. In general, we discuss how our costs by type have changed since the last negotiation period relative to inflation and share other details about our cost structure that are relevant and may distinguish us from other peer hospitals. We have been able to carve out direct costs for high cost operating room supplies and drugs with many payers so that we at least recoup those in addition to flat rates for the procedure or inpatient stay. Payers have not been willing to recognize and cover the full costs of inpatient care. As the standard of care for many procedures shifts from the inpatient setting to the outpatient setting, and rates are higher than cost for the outpatient care, we are at risk if we lose outpatient volume of not being able to cover the cost of the inpatient care we provide. As an example, the latest payer contracting trend is to designate preferred networks for certain services such as laboratory services as mentioned in response to question 3.

9) Do you generally negotiate contracts with carriers as part of a larger system or as an individual facility? Is there a material difference in how you approach contracts when you are contracting as part of a system vs. as an individual facility?

RESPONSE:

Summary: Lawrence General Hospital is an independent facility and therefore we negotiate on our own. We recently formed a Physician Hospital Organization (PHO) with 150 of our local community physicians in our Independent Practice Association in order to gain negotiating clout for both parties. This has been only moderately successful and mostly with payers with low market share to date. There has been no material difference in how we approach contracting as we still try to use a data driven approach.

10) If applicable, do the services provided in your outpatient facilities in suburban areas differ from those in Boston? If so, how? For those services offered in both locations, do you charge the same or similar rates for all locations? If not, how do the rates – or price paid per person - differ and based on what factors? Are these facilities competing with community physicians or hospitals, or both for the same patients?

RESPONSE: This question does not apply to Lawrence General Hospital.

11) How has the expansion of outpatient facilities impacted the composition of surgical and medical admissions to your institution? How has the expansion of outpatient facilities impacted the price or cost paid per person of your institution?

RESPONSE:

Summary: In our service area, we have had competition from outpatient surgical centers, free standing labs and imaging facilities primarily. We have seen the impact in our payer mix where Medicaid makes up a growing proportion of our revenue, and our utilization mix, with more costly surgical procedures being done at the hospital. The expansion of outpatient facilities in the region has negatively impacted the price paid for these services at the hospital.

Detail: The more costly procedures are not necessarily more profitable ones, and we have to wait before we have a chance with multi-year payer contracts to adjust payment rates to the new mix where possible. Medical admissions are not impacted by outpatient facility competition but are negatively affected by variable payer rules defining observation status vs. inpatient status. The expansion of outpatient facilities has negatively impacted the price paid for these services at the hospital. Using the previous lab example, payers are putting downward pressure on our rates since they can drive the business elsewhere to save money at a lower cost freestanding facility. So the expansion of other outpatient facilities that have lower overhead and accept lower payment rates from payers negatively affects the price payers are willing to pay for the same services in the hospital setting.

12) How does the variation in prices among different providers in your peer group (e.g., teaching/community hospitals, providers in your geographic area, your key competitors) affect the payment rate increase you seek in negotiations with health plans? Please provide an explanation of how you define your "peer group".

RESPONSE:

Summary: We consider our peer group to be similarly sized community hospitals in our geographic area, although we also consider how we differ from them. Peer group payment rates are not available to us due to payer provider confidentiality clauses, so are not taken into account in our contract proposals.

Detail: Our cost structure differs from some of our peer group members because we are a teaching hospital for family practice, we employ our emergency room physicians, and our uncompensated care has been historically higher.. We do expect that we would be at least competitive with the rates these hospitals receive, but we have no idea if we are or not because there has been limited transparency, enforced by payer contract confidentiality clauses. The HCQCC data gives a glimpse of comparison, but is not payer specific. Therefore we propose rates that we need as an independent hospital and cannot take into account peer group payment rates because they are not made available to us.

With respect to the aggregate trends, please comment:

13) What specific actions has your organization taken already to address these trends in the short term or long term? What current factors limit the ability of your organization to execute these strategies effectively?

RESPONSE:

Summary: To address increased emergency center utilization, we are attempting to increase primary care capacity in the community so that lower level, non-emergent care can be handled in the less costly office setting. Certain payer contract incentives for our community physicians include appropriate use of the emergency room. We are providing utilization data to the primary care community so that they can follow up with patients and influence future utilization as well.

14) What types of systemic changes would be most helpful in reducing cost trends without sacrificing quality and consumer access? What other systemic or policy changes do you think would encourage or help health care providers to operate more efficiently? What changes would you suggest to encourage treatment of routine care at less expensive, but appropriate settings?

RESPONSE:

Summary: As previously stated, benefit design that requires patients to pay more for using higher cost facilities for less intensive procedures would help direct care to the less expensive and appropriate setting. Along with more patient education on use of their benefits, there should be more designs that encourage and reward healthy behaviors. Payers should take on the burden of billing patients for deductibles and coinsurance since they are already set up for premium billing and mailing of Explanations of Benefit. This would reduce provider costs. Administrative simplification such as standardized medical necessity guidelines, medical management processes, and claims edit rules could help reduce business costs on the part of both payers and providers without sacrificing quality and access.

15) Could enhanced competition or government intervention or a combination of both mitigate the cost trends found in the Divisions report? Please describe the nature of the changes you would recommend. In addition, please address the following:

a. What would be the impact on your organization of making data public regarding quality and the reimbursement rates paid by each carrier to each hospital or system in a manner that identifies all relevant organizations? What is the advantage or disadvantage to your organization of the current confidential system?

RESPONSE:

Summary: Enhanced competition with the current system of leverage determining private payer rates would not mitigate trends. Providers with market clout, related leverage and larger systems would dominate as they do now. Creative benefit design that includes higher cost sharing for patients who choose higher cost facilities for services available at lower cost settings would be a first step toward mitigating cost trends.

Detail: Transparency is paramount. Payers should be required to disclose their rates and not be able to hide the amounts paid to different facilities and physician communities. Hospitals like Lawrence General are disadvantaged by the current system and unable to make investments in infrastructure needed to make improvements that attract patients, and enhance quality and efficiency. The payers should be required to align payment and resource use and/or payment and quality. We had a more rational system when providers were paid a percent of charges for their services, since charges correlate to resource use and therefore payments would as well, and there

weren't millions of dollars spent by payers trying to figure out how to deny claims or make providers jump through hoops to get paid. In the percent of charge system there should be responsibility on the provider's part to justify charge increases, but this would restore some market forces to the system along with current efforts to make quality and cost transparent to the consumer. In lieu of that, government could intervene and set the rates for all insurance plans.

With respect to future years' Cost Trends Reports:

16) Please identify any additional cost drivers that you believe should be examined in subsequent years and explain your reasoning.

RESPONSE:

Summary: Other elements of cost that should be examined include pharmaceutical costs, RN staffing, capital credit costs, as well as capital investment costs.

Detail: It is well known that pharmaceutical cost has been increasing at high rates and there seems to be little control over those companies other than restrictions on marketing to physicians. Their consumer advertising drives up utilization of brand name drugs despite payer efforts to incentivize generic prescribing. It is a high cost area for the hospital as well over which we have limited control. We live with the presence of unions for our nursing staff and technical support personnel, but the nurses' union has taken an unfair share of our labor expense and should be involved in discussions of health care cost containment. Accessing capital comes at higher rates and can be prohibitive for a hospital with Lawrence General's payer mix because the marketplace sees providers with high public payer mix as higher risk. Enhancing access to capital would allow providers like Lawrence to make investments that would attract more private pay patients to a high quality low cost setting.

17) Please provide any additional comments or observations you believe will help to inform our hearing and our final recommendations.

RESPONSE:

Summary: The Attorney General's report described the rates DSH hospitals are paid as 10 – 25% less than other hospitals. This is attributable to our lack of market clout or leverage. Without some mechanism which dictates that rates for DSH providers are enhanced these providers will continue to close services and fail. DSH hospitals are among the most cost effective settings, and have been left behind. Any major system redesign must take into account the disadvantaged position of these providers.

Exhibit C: AGO Questions for Written Testimony

LAWRENCE GENERAL HOSPITAL TESTIMONY
March 3, 2010

Questions

1) Please explain and submit a summary table showing your internal costs and cost trends from 2004 to 2008 broken out to show categories of aggregate direct costs (e.g., labor costs for all cost centers) and categories of indirect costs including, but not limited to, debt service, depreciation, advertising, bad debt, stop-loss insurance, malpractice insurance, health safety net, development/fundraising, administration, research, academic costs. Please explain and submit supporting documents to show the methodologies you use to allocate the categories of indirect costs to cost centers (operating units).

RESPONSE:

Summary: Please reference the Exhibit for this question, attached, showing the trends in the categories listed above. Due to our new Emergency Center opening in 2006, you will notice increased fundraising costs in 2005 and our debt service beginning in 2006. Our malpractice expense increased in 2007 and 2008 due to growth of our employed hospitalist program. Our academic expense relates to our family practice residency program shared with the Greater Lawrence Family Health Center.

Detail: Lawrence General Hospital allocates the categories of indirect costs to cost centers (operating units) in accordance with DHCFP-403 reporting instructions. The DHCFP-403 instructions for Schedule XIII, Step-down Statistics, dictate the required statistical base that must be employed for allocation purposes. Lawrence General Hospital has not requested nor been granted an approval to utilize any alternative allocation methods. Lawrence General Hospital's FY2008 As-Filed DHCFP-403 Cost Report Schedules XIII, XIV, and XV and the DHCFP-403 reporting instructions are provided in support of this response.

2) Please explain and submit supporting documents that show any steps you have taken to reduce or control the growth of your internal direct or indirect costs in the last 5 years.

RESPONSE:

Summary: Lawrence General has to be continually vigilant on controlling the growth of expenses given our limited ability to increase our prices. During the past five years we have had initiatives in labor cost control, materials management, patient financial services, hospital-wide charge capture review and postponement of capital expenditures.

Detail: We have created a position control that has allowed stricter control over labor costs. Non-nursing salaries have only increased by 2% or 3% per year. In Materials Management, we have participated in the Voluntary Hospital Association's group purchasing organization where there have

been savings and created our own savings program where there were opportunities with vendors. We put many of our vendor contracts through a competitive re-bidding process to accomplish this. We renegotiated contracts with our patient accounts business partners for savings on outsourced services. We have reviewed our clinical processes to insure all services are documented and charges are properly captured. We asked each department to reduce their expenses by a certain percentage when necessary and have postponed budgeted capital expenditures as necessary when tightening our belt. We have invested in systems to improve our efficiency as well, such as our new operating room system, medication management system and NEHEN for our patient accounts processes.

3) Please explain and submit a summary table showing your annual operating margins (positive or negative) from 2004 to 2008 for your entire commercial, government, and all other business (and please identify the carriers or programs included in each of these three aggregate margins). Please explain and submit supporting documents to show the mechanics of how you calculate your margin from your accounting system and identify whether you exclude any direct costs or indirect costs, or include any grants, donations, or non-patient revenue, in calculating your margins.

RESPONSE:

Summary: Lawrence General has achieved an operating margin in 3 of the last 5 fiscal years. This is due to prudent fiscal management, minimal physical plant expenditures and effective revenue cycle strategies. The margin growth in 2007 and 2008 was primarily the result of effectively managing labor costs, carefully monitoring all expenses and improvements in services offered to the community such as the new Emergency Center. We have also benefitted from the lower cost of capital due to the drop in interest rates during this period.

Operating Margin					
	2004	2005	2006	2007	2008
Lawrence General Hospital	0.59%	-2.25%	-0.24%	1.81%	1.69%
LGH Charitable Trust	7.20%	15.14%	32.84%	94.03%	96.42%
LGH Health Enterprises	7.61%	-1.86%	1.50%	8.07%	5.60%

Lawrence General Hospital and Affiliates calculate Operating Margin by dividing Income from operations over total revenue. Income from operations excludes non operating items such as any income/loss from investments activities and any unrealized loss/gain from the investment portfolio. Total revenue includes net patient service revenue along with other operating gains that may include grants, donations and other non-patient related revenue. Direct and indirect costs are included in income from operations.

4) Please explain and submit supporting documents that show how your DHCFP-403 Cost Report submission differs from your own internal cost information including any difference in direct costs, indirect costs, or non-patient revenue.

RESPONSE:

Summary: Lawrence General Hospital's DHCFP-403 Cost Report submission does differ from its own internal cost information. The root cause of the variance is the DHCFP-403 reporting instructions that (1) require the HSN Assessment to be added to the Hospital's reported expenses, and (2) require bad debt recoveries be included on Schedule VII, Other Income and Recovery of Expense. After these variances in reporting methodologies are taken into consideration, the Hospital's direct costs, indirect costs, and non-patient revenue reported on its DHCFP-403 Cost Report reconciles to its internal financial statements. (See Exhibit for this question)

Detail: Lawrence General Hospital's direct and indirect costs reported on Schedule II of the DHCFP-403 vary from its internal cost information by the HSN Assessment. This variance is a direct result of the reporting instructions for the DHCFP-403 Cost Report. Schedule II, Column 2 of the DHCFP-403 includes both direct and indirect costs. Indirect costs are properly classified as overhead on Schedule II and are included in the total expenses of the Hospital on its financial statements. The Hospital does not have any unique indirect costs, such as home office or research costs, that could potentially be allocated differently on the DHCFP-403 submission and its internal financial statements.

Lawrence General Hospital's non-patient revenue, as reported on Schedule VII of the DHCFP-403, varies from its internal financial statements. This variance is a direct result of the reporting instructions for the DHCFP-403 Cost Report that requires bad debt recoveries to be included on Schedule VII.

5) Please explain and submit a summary table showing your annual capital ratio, debt service coverage ratio, and cash on hand for fiscal years 2004 to 2008 and include any target ratios and cash position you have set to obtain bond or bank financing. Please explain how your capital expenditures (property and equipment), restricted capital donations, and changes in cash position (endowment) have increased or decreased your internal costs and margin calculations.

RESPONSE:

Summary: The Hospital has made improving its ratios and cash on hand a top priority because the average age of the plant is nearly 50 years, a substantial proportion of the campus is fully depreciated, and it is imperative that the hospital be able to access capital to improve and enhance the physical plant.

Detail:

Lawrence General Hospital					
	2004	2005	2006	2007	2008
Debt Service	No Debt	3.62:1	6.21:1	13.61:1	20.00:1
Cash on Hand	54	55	73	87	100
Working Capital / Current Ratio	2.01	1.58	1.85	1.91	1.85

Lawrence General Hospital and Affiliates calculates the above ratios as follows:

- The Debt Service ratio is calculated by taking the net earnings of Lawrence General Hospital and LGH Charitable Trust for 12 consecutive months, less interest, taxes, depreciation and amortization. That amount is divided by interest expense plus principal loan payments due for the period.
- Cash on Hand is calculated by taking cash plus marketable securities & investments divided by total expenses less depreciation divided by 365.
- Working Capital / Current Ratio is calculated by taking total current assets and dividing by total current liabilities

The above ratios along with other ratios, for example, AR days, AP days, Operating Margin, Cash to Debt are compared against an internal target of a BBB bond rating to determine the Hospital's ability to obtain reasonable interest rates for its debt financing.

6) Please explain and submit supporting documents that show your internal costs, including any stop-loss coverage, for any risk you currently bear related to your contracts with commercial insurers. Please include any analysis you have conducted on how much your costs and risk-capital needs would change based on increases or decreases in risk you bear in relation to your business with commercial insurers.

RESPONSE: Lawrence General Hospital does not currently have any risk contracts with insurance plans so this question is not applicable.